MEDICAL HISTORY

NAME: ___________________________ AGE: _____ DATE OF BIRTH: __________ DATE: __________

Have you ever had or been treated for the following conditions:

❒ Allergies	❒ Blood Disease	❒ Blood Pressure	❒ Back Trouble
❒ Hay Fever	❒ Cancer	❒ Heart Disease	❒ Arthritis
❒ Asthma	❒ Diabetes	❒ Kidney Disease	❒ Chronic Pain
❒ Emphysema	❒ Low Blood Sugar	❒ Bladder Problems	❒ Headaches
❒ Skin Problems	❒ Thyroid Problems	❒ Prostate Disease	❒ Injury/Fracture
❒ Constipation	❒ Liver Disease	❒ Menstrual Problem	❒ Epilepsy/Seizure
❒ Stomach Problems	❒ Hearing Problems	❒ Abortion/Miscarry	❒ Eating Disorder
❒ Irritable Bowel	❒ Vision Problems	❒ Sexual Problems	❒ Drinking Problem
❒ Weight Problems	❒ Dental Problems	❒ Sleep Problems	❒ Drug Abuse

Please list any hospitalizations (dates and reasons):____

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Please list all prior mental health services received:

With Whom: Year: How Long: For What:

Are there any physical problems in the family that concern you?

Are there any emotional problems in the family that concern you?

Have you ever been: physically abused ❒ or sexually molested ❒ ?

Are you currently under the care of a doctor for any physical or emotional condition?
If so, please list doctor's name, reason for treatment, date last seen:_______________________________

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Current medications you are taking:____

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Current Health Concerns: Please check any area where you think you may have a problem:

❒ Hearing/Vision	❒ Anxiety/Nervousness	❒ Interpersonal Relationships
❒ Speech	❒ Depression	❒ School Problems
❒ Dental Health	❒ Anger or Temper	❒ Work/Job/Career Problems
❒ Breathing	❒ Frequent Mood Changes	❒ Marital Problems
❒ Circulation	❒ Guilt	❒ Parenting Skills
❒ Digestion	❒ Self-Concept	❒ Sexuality
❒ Bowel Function	❒ Tiredness/Fatigue	❒ Problems with Relatives
❒ Urinary Function	❒ Sleep Disturbances	❒ Legal
❒ Joint/Muscle Function	❒ Suicide Ideas	❒ Exercise, Hobbies
❒ Skin Condition	❒ Indecision	❒ Drinking Problems
❒ Pain	❒ Memory/Concentration	❒ Drug Problems
❒ Menstrual Cycle	❒ Eating/Appetite	❒ Behavior Problems
❒ Menopause	❒ Weight Loss/Gain	❒ Other:_________________
❒ Smoking	❒ Phobias	_______________________

Name of your physician: ____

Client Signature: ____ Date: _________________